AUTHORIZATION FOR MEDICAL INFORMATION

[City], [state]
Dated: _____

TO WHOM IT MAY CONCERN:

This authorizes the physicians, hospital and all medical attendants to furnish full and complete medical reports and information requested by the undersigned to _____, Attorney at Law, or to any representative or investigator from his firm, and especially any and all medical reports concerning treatment I have received since ____ day of _____, 20__. This authorization also includes examination of all hospital records, x-ray film and furnishing of any information including opinions, which will aid the said attorney in the prosecution of claims against insurance carriers, and others for injury sustained.

Your full cooperation with my attorneys is requested. You are further requested not to disclose such information to any other person without written authority to do so.

HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually

identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

ALL PRIOR AUTHORIZATION IS HEREBY CANCELLED.

_____

Patient